**Communication Skills**

**Intro to Interviewing – August 29, 2012**

***Notes***

* Interview (relationship, patient’s experience of illness), history taking (problem diagnosis, disease), negotiation
* Patient physician relationship = increase patient satisfaction, return visits, compliance, clinical outcomes and decreases malpractice suits
* Elements of an interview: opening/setting patient at ease, establish reason for interview (chief complaint), logical questioning (from general to specific questions), closing, respectful, interested, empathic communication
* Complete history: patient’s story from the patient’s perspective, fine tuned by the physician, shared project

***Objectives***

1. Recognize commonly used interviewing techniques when presented with patient-physician dialogue
   1. Nonverbal communication
      1. Seating arrangement, eye contact, volume of voice, eye contact, head nodding, silence, facial expression, sighing, tone of voice
   2. Open-ended questions
      1. Use general questions to get the patient’s description of symptoms
   3. Direct (Closed) Questions
      1. Detailed question about specific information about a certain fact, range of possible answers restricted
      2. “When did the chest pain begin?” “What did your father die of?”
   4. Facilitation
      1. Verbal or non verbal open-ended approach, encourages patient to say more about their feelings or problems, demonstrates interest and concern with what patient is saying
      2. “You did?” Head nod, “Uh-huh”, “Anything else?”
   5. Reassurance
      1. Puts patient at ease, but don’t give false hope or overuse
      2. “That’s a lot to take on.”
   6. Confronting
      1. Describes perception of patient’s verbal and nonverbal communication, draws attention to what the patient may be trying to avoid
      2. “You seem depressed when you talk about that.”
   7. Silence
      1. Gives patient time to respond to difficult questions or venting feelings, must closely time (promotes closeness and allows patient to continue talking about a difficult subject)
   8. Reflection
      1. Includes repetition of patient’s words to encourage expansion in regards to details and feelings
      2. “So you used to get the headaches back then.”
   9. Transitions
      1. Tells patient when you are changing gears
      2. “Now I’d like to ask you questions about other health problems you may have”
   10. Summarization
       1. Draws all info together and clarifies it for patient, check understanding of patient’s story and allows patient to add or restate important information
       2. “It seems you were feeling well until 2 weeks ago when you first had the chest pain.”
2. Describe the elements of a comprehensive health history
   1. Chief Complaint (CC)
      1. One or more symptoms or concerns causing the patient to seek care, in own words (quote)
   2. History of Present Illness (HPI)
      1. Amplifies CC using patient’s perspective (patient’s thoughts and feelings about the illness) and describes how each symptom developed (dimensions of symptoms)
         1. Dimensions of a symptoms: location, onset/duration/frequency, precipitating (worse) and palliating (better) factors, quality, radiation, severity, temporal (setting where it occurs), associated symptoms
         2. Patient’s perspective: “What do you think is causing your problem?”
   3. Past Medical History
      1. Past illnesses, injuries, hospitalizations, surgeries, allergies (reaction?), immunizations, substance abuse (type, route, quantity, frequency, tobacco, alcohol, drugs), diet, current medications (dose, route, frequency) complementary/alternative therapies
   4. Health Maintenance
      1. Routine checkups, health screenings, self-examination, smoking cessation, exercise, safety
   5. Family History
      1. Health and illnesses of immediate family (parents, grandparents, siblings, children, grandchildren)
   6. Psychosocial and Spiritual History
      1. Education, life experiences, personal relationships
   7. Sexual, Reproductive, and Gynecologic History
      1. Sexual History: interest, function, satisfaction, practices, problems, STDs
      2. Reproductive/Gynecologic History: number/complications of pregnancies, deliveries, abortions, age at menarche, regularity of menstrual flow, duration of periods
   8. Review of Systems
3. Elicit a comprehensive health history from a standardized patient
   1. Do it.

**Building the Relationship – September 05, 2012**

***Notes***

* Appropriate touch varies, male to male: usually hands, female to female: arms, hands, female to male: arms and hands, head to waist, male to female: head to shoulders, arms and hands
* Distraction and anxiety effect communication, take care of your own needs before an interview
* Non-judgmental acceptance (acceptance is not agreement)
* After opening the interview and inviting the patient’s story, you will need to collaborate and negotiate a plan (education, health behavior change intervention)

***Objectives***

1. Recognize common relationship building skills
   1. Rapport building: Listen more, talk less, interrupt infrequently
      1. Introductions/patient comfort
      2. Convey some knowledge of patient’s history/acknowledge lack of knowledge
      3. Notice body language (yours and theirs)
      4. Be emotionally present
      5. Ask question about patient’s broader life
      6. Don’t appear to be in a hurry
      7. Disney technique (onstage technique)
   2. Elicit patient concerns
      1. Speak directly to the patient, “What else?”, more than how they feel (also is how they think it started and how it impacts their life)
      2. Ask about patient’s ideas, views, concerns, “How has the problem affected your daily activities?”
   3. Set the agenda: “I want to hear what has brought you in today and then I will have some specific follow-up questions for you.”
   4. “Active” Listening: listening for meaning in what your patient says and what their body conveys, goal is to improve mutual understanding between you and your patient, collaborative and patient’ centered
      1. Audition (listen), Evaluation (relevant from irrelevant data), Inquiry (probe into important areas), Observation (nonverbal communication), Understanding (concerns and apprehensions)
   5. Provide support: concern, understanding, partnership, sensitivity
2. Distinguish between doctor and patient perspectives
   1. Paternalism: greater doctor contribution to the interview than patient (greater doctor perspective, reality, experience, knowledge)
   2. Patient centered: greater patient contribution (patient perspective, reality, experience, and knowledge)
3. Describe how nonverbal, empathy, questioning, and reflective skills are used to enhance the Dr/Patient relationship
   1. Nonverbal: 85% of communication, paralanguage (tone, rate, volume, emphasis), body posture, facial expressions
   2. Questioning: closed (yes or no) vs. open (max. choice in responding)
   3. Reflection: helps prevent miscommunication (what patient says, what clinician hears, what clinician understands, what patient means), use of reflection helps enhance the last step
   4. Empathy: reflections and interruptions

**Societal Aspects of Interviewing and the Physician-Patient Relationship – September 12, 2012**

***Notes***

* Framework used for clinical decision making over time: experience-based medicine, knowledge-based medicine, evidence-based medicine, values-based medicine
* Medical culture examples: hospital rounds, mandatory attire, privacy curtains, etc.
* Aspects of cultural identity: ethnicity, race, country of origin, language, gender, age, religion, education, socioeconomic status, marital status, sexual orientation
* Ethnicity: subjective, self-defined, relates to each individual’s identity with a group, may be through nationality, shared history, religion, cultural patterns, etc.
* Geographic ancestry: objective, genetic relationships, more accurate to determine biological risk factors than race alone (genetic ancestry highly correlated with geographic ancestry but correlation with race is modest)
* 2000 US Census: 6 race categories and 2 ethnic categories (Hispanic origin or non, can be of any race), 63 possible combinations of population categories
* Milton Bennett’s Developmental Model of Intercultural Sensitivity: denial, defense, minimization, acceptance, adaptation, integration
* Cultural competence: results in active application of awareness, knowledge, and skills in health care delivery, usually doesn’t occur naturally, moves us away from ethnocentricity (where we use our own cultural rules to judge people different from us) to ethnorelative
  + Cultural destructiveness (differences are a problem), cultural incapacity, cultural blindness (all are alike), cultural pre-competence, basic competence, advanced (educates, interacts with other backgrounds)
* Stereotype: ending point, no attempt is made to learn if your individual fits your assumption
* Generalization: starting point, more info collect to check if they fit with assumption
* Spirituality: individual’s sense of the transcendent, sense that there is something bigger than self
* Religion: adherence to a faith tradition in practice (outward expression or tradition), belief (acceptance of doctrine, changes behavior and harder to measure), or both
  + Constructed by a community of believers, many components but can’t assume that spirituality is one of them
* Psychiatry’s DSM-IV Outline for Cultural Formulation: cultural identity of person, cultural explanations of person’s illness, cultural factors related to environment, cultural elements of patient physician relationship, overall cultural assessment for diagnosis and care
* Using Interpreters: therapeutic triad, nonverbal cues between patient, clinicians, and interpreter, verbal through patient and interpreter and clinician and interpreter

***Objectives***

1. Discuss the importance of attempting to deliver person-centered care
   1. Allows us to customize care and provide empathy for our patients while diminishing potential conflicts down the road
2. Define *culture* and discuss its various dimensions in medicine
   1. **Culture** is a set of learned and shared beliefs and values, that are applied to social interactions and the interpretation of experiences
   2. Framework that shapes and directs how we behave and how we interpret the behavior of others
   3. It influences how we experience illness and how we make health-care decisions
   4. Dimension of medical culture: privacy, communication, socioeconomic status, immigration status, approach to decision making, beliefs explaining health and illness, focus of attention (on illness rather than wellness), healing traditions
3. Discuss the difference between *disease* and *illness*
   1. **Disease** is an abstract (theoretical) way to explain problems, defined using structure or function of body organs and systems
   2. **Illness** is an individual’s personal experience of ill health
4. Describe how culture relates to health… and illness
   1. Many people have differing views on illnesses and life and it may require you to work with the patient to come up with a plan that works for the patient and the doctor
   2. Culture influences an individuals understanding of sickness and health
   3. Various explanations for diseases: supernatural cause, lack of faith, imbalance, biological influences
   4. Type of explanatory models of disease
      1. Moral, religious, magical medical (western allopathic, traditional Chinese, homeopathy, Ayurvedic, osteopathy, herbal medicine)
      2. Consequences of conflicting explanatory models: patient physician (decreases rapport, treatment non adherence and termination), patient family (lack of support, shape), patient community (social isolation, stigmatization)
      3. Kleinman’s Questions: used in eliciting an individual’s explanatory model
   5. Health disparities are population-specific differences, race plays role in creation and maintenance of disparities
      1. Related to access to care, utilization of resources, health outcomes, barriers to optimal health, general health
   6. Cultural competence in medical practice enhances physician’s understanding and respect for individual’s beliefs, values, and expectations, awareness of own assumptions and values as well as those in the US health care system, and ability to adapt approach in meeting the needs of each patient
      1. Doesn’t require an extensive knowledge of cultures but does require intentional, thoughtful, and systematic approach to delivering person-centered health care
   7. Benefits of cultural identity assessment
      1. Identification of potential strengths and vulnerabilities, potential areas of cultural conflict, better appreciation for patient’s perspective, assistance in building rapport with patient
   8. Religion impacts clinical decisions
      1. Examples: Confucianism (discourage medications), Buddhism (accept illness and do nothing), Taoism (alternative healing to balance chi)
5. Discuss the relationship between effective communication and delivery of quality health care
   1. How can a patient know what to do or even follow what is happening if they have no say in it or just simply don’t understand what is going on?
6. Describe two models used to promote cultural understanding in the practice of medicine
   1. LEARN model
      1. L – listen with sympathy and understanding to the individual’s perception of the problem
      2. E – Explain your perception of the problem
      3. A – Acknowledge and discuss differences and similarities
      4. R – Recommend treatment/solution
      5. N – Negotiate an agreement
   2. RESPECT model
      1. R – Rapport – Connect interpersonally , avoid assumptions, view situation from patients POV, non-judgemental
      2. E – Empathy – Understand patient’s rationale for behavior and illness, verbally acknowledge and legitimize feelings
      3. S – Support – Identify barriers to care, help patient overcome barriers, reassure availability to help, involve family when appropriate
      4. P – Partnership – Collaboration in addressing problem, be flexible,
      5. E – Explanations – Check individual’s understanding frequently using verbal clarification
      6. C – Cultural Competence – Respect their beliefs and culture, understand that their views of medicine may be defined by ethnic, cultural, or past experiences, be aware of own biases
      7. T – Trust – Understand self-disclosure is difficult for some, establish therapeutic relationship based on trust
7. Explain why physician – patient negotiation is important
   1. A plan that a patient comes up with is more likely to be followed because they had a say in it. It’s sort of like Inception

**Assessment of Family Violence – September 19, 2012**

* Physical Assault: more men than women physically assault as a child by an adult attacker or as an adult, but women are more likely to be injured than men
* Stalking: more women than men are stalked, 81% of women stalked by current or formed partner are physical assaulted and 31% are raped
* Rape: more women than men are raped, more women victims are physically injured during rape than male victims
* Intimate Partner Violence: majority (85%) female victims, most often victimized by someone they knew, most cases no reported to police, major public health concern
  + Relationship Risk Factors: stems from power and control, intimidation, isolation, emotional abuse, economic abuse, sexual abuse, using children, threats, using male privilege
  + Greater risk for females 20-24 years of age for nonfatal IPV
  + 40-45% of IPV relationships also involve sexual assault/forced sex
  + Significant morbidity and mortality: 1/3 of female homicide victims filled by intimate partner, in 70-80% of IPH (regardless of partner killed) the man abused the woman before the murder
  + Less than 20% of IPV victims that are injured seek medical treatment
  + Socioeconomic consequences for IPV: direct and indirect medical costs, lost days of work, social isolation/stigma, homicides and injuries
  + Psychological consequences: high rates of depression, substance use, antisocial behavior, suicide (female teens), anxiety disorders, low self esteem
* Witness IPV is strongest risk factor for transmitting violent behavior to next generation (boys who witness IPV are 2x likely to beat own kids and partners)
  + Perpetrator risk factors: witnessing violence and experiencing violence as a child, young age, low self-esteem, low income, low academic achievement, aggressive behavior, drugs and alcohol use, social isolation, unemployment
  + 30-60% of IPV perpetrators also abuse children
* Aside from injuries, medical costs of IPV include CAD/PAD, stroke, HTN, cancer, autoimmune diseases, liver diseases/cirrhosis due to psychological effects and life style, as well as mental health issues (depression, anxiety, suicide)
* Presentation
  + Pattern Recognition
    - Primary skill set of clinicians, differentiates novice from expert, increases efficiency of diagnosis, good for common problems presently commonly, poor for uncommon presentations of common problems or common presentations of uncommon problems
  + Index Patient: woman, child, rarely male as presenting patient
  + Location: office, EF, hospital
  + Circumstances: routine visit, acute injury
  + Symptoms
    - Somatic: headaches, chest and pelvic pain, insomnia, heart palpitations, choking sensation, GI symptoms, fatigue, numbness, tingling, hearing loss
    - Psychological: depression, isolation and inability to cope, suicidal thoughts, panic attacks, alcohol or drug abuse, PSTD or reaction
    - Psychical: apparent shyness, fear, evasiveness, lacerations, hematomas, fractures, abrasions, burns (mostly on face, neck or trunk), injuries at various stages of healing
* Detection
  + Direct assessment: part of office or ED visit (Joint Commission Requirement)
  + Indirect assessment: provide information in office and ED: PSAs, phone numbers, brochures
  + Just ask: simple, direct, neutral questioning, when patient alone, ask male patients as well
  + Partner Violence Scale: have you been hurt by someone in the past year, do you feel safe in your current relationship now, is there a partner from a previous relationship making you feel unsafe now
  + For teens: indirect methods of ask, ask if friend or know someone who was hurt by a partner
  + Once identified, ask about:
    - Presence of children (reportable in many locations)
    - Escalation of violence
    - Weapons in the house
  + Barriers to Detection
    - Physician: fear of being overwhelmed by response, perceived lack of time, don’t know how to ask, denial, projection, not a true medical issue ideal
    - Patient: hope for change, isolation, societal denial, barricades from batterer, dangers in leaving, economic autonomy
* Once identified: supportive listening (non-judgmental), label the abuse, give options to assure safety
  + Interventions: give validating supportive messages, work through denial (label it as abuse and wrong), plant seeds for change (assess readiness, talk about options), offer to call for them, offer resources, discuss safety/escape plan
  + Contact Children Services if children are present and may be targets of violence
  + Document statements, injuries, and photograph if possible
* Don’t’: encourage confrontation, tell the patient what to do, encourage couples counseling
* Do: assess danger level and inform patient, schedule follow up

**Screening for Depression and Alcohol Misuse – September 19, 2012**

***Notes***

* Depression is second behind ischemic heart disease in lost years of healthy life, economic burden
* Should screen for depression because it is a common disorder, we have effective treatments, early treatment improves outcomes, we have validated screening tools
* Screening tools: questionnaires, can indicate severity, can be used to monitor response to treatment, can test for other disorders
* Indications for depression screening: first degree relative with depression, more than 2 chronic diseases, obesity, chronic pain, pregnancy, elderly, multiple vague symptoms
* Must assess suicide risk: ask if they feel if they would be better off dead, determine if they have a plan, psychotic symptoms (command hallucinations), history of previous attempts
  + Asking doesn’t implant thoughts
* Positive screen of depression is not a diagnosis (positive predictive value of 25-40%)
* One drink is 12 Oz beer, 5 oz wine, 1.5 oz of 8- proof liquor
  + Moderate drinking (low risk)
  + Heavy drinking (high risk, women more than 7 drinks a week or 3 at a time, men more than 14 drinks a week or 4 at a time)
  + Binge drinking (high risk, women more than 4 drinks at a time, men more than 5 drinks at a time)
* Screen for alcohol misuse in all adults

***Objectives***

1. Outline the diagnosis of Major Depressive Disorder
   1. DSM-IV Criteria: Five or more of the following for at least 2 weeks
      1. Depressed or irritable Mood
      2. Sleep Problems
      3. Diminished Interest or Pleasure from most activities (anhedonia)
      4. Feelings of worthlessness or Guilt
      5. Fatigue or loss of Energy
      6. Impaired Concentration or indecisiveness
      7. Change in Appetite or weight
      8. Psychomotor agitation or retardation
      9. Recurring thoughts of death or Suicide
      10. (SIGECAMPS)
   2. Clinically significant distress, change from previous functioning, not caused by direct effects of substance or medical condition, not accounted for by bereavement, no manic or hypomanic episodes
      1. Certain medical conditions are associated with depression (hypothyroidism, CVD, Pancreatic Cancer, dementia, HIC, Parkinson’s, Huntington’s, MD, epilepsy, chronic pain
      2. Certain substances are associated with depression symptoms (alcohol, benzodiazepines, corticosteroids, marijuana, stimulant withdrawal, opiates)
2. Define types of alcohol misuse
   1. Risky drinking – Drinking way too much, amount exceeds recommendations
   2. Problem drinking – drinking that results in physical, social, or psychological harm
   3. Alcohol abuse and dependence – Results in repeated harm, but unable to change pattern
3. Outline the use of paper and pencil screening tools for alcohol misuse and depression, including the PHQ-9 and the AUDIT
   1. AUDIT (Alcohol Use Disorder Identification Test)
      1. 10 questions about quantity and user’s experience with alcohol
      2. 80% sensitive and specific for heavy drinking or dependence
   2. PHQ-9
      1. Questionnaire designed to identify patients that are depressed
      2. Low 90% for sensitivity and specificity
4. Utilize brief verbal screening techniques for depression and alcohol misuse, including the Two Question tool and the CAGE questions
   1. 2 question tool – used to determine depression
      1. “Over past 2 weeks, have you felt down, depressed or hopeless?”
      2. “Over past 2 weeks, have you felt little or no pleasure in doing things?”
      3. A positive answer to 1 or 2 questions is 85% sensitive and specific
   2. CAGE – 4 questions asked to determine alcohol problems
      1. Have you ever felt you should *cut down* on your drinking?
      2. Have people annoyed you by criticizing your drinking?
      3. Have you ever felt bad or *guilty* about your drinking?
      4. Have you ever had a drink first thing in the morning steady nerves and get rid of a hangover (eye opener)?
      5. One affirmative answer requires more investigation, 2 or more considered positive
      6. 77% sensitive, 80% specific for dependence
      7. May not be accurate in some groups (women, ethnic groups, binge drinkers)
      8. Can be modified from drug use
5. Demonstrate interviewing techniques for difficult topics
   1. You have to bring the topic up yourself, since patients are reluctant to do so
   2. Ask questions in destigmatizing, empathetic way, don’t lead [patient to answers, talk about neurobiology/chemical imbalance
   3. For alcohol screening, start with asking how much alcohol (not do you), follow up on vague answers, patients may underestimate use by half, <50% sensitivity

**Documenting a Patient Encounter – September 20, 2012**

***Notes***

* Users of medical records: hospitals, rehab, PT, home health, quality reviews, HMO, students, attorneys, researchers
* Uses: coordinate care, assess quality of care, minimize risk, train students, conduct research
* Complete and accurate medical records = less malpractice suits, proper reimbursements
  + Courts can infer negligence where medical records fail to include certain data
* 3 Rules of Charting
  + No Record = Didn’t Happen, Illegible = Worthless, Unorganized = No Value

***Objectives***

1. Describe and recognize characteristics of “good” patient documentation
   1. Comprehensive/Complete/Clear/Descriptive/Concise
      1. Avoid imprecise language, generalizations
   2. Legible/Accurate/Organized
   3. Discrete/Respectful
   4. Timely
2. Discuss and apply techniques to minimize liability (risk management) when documenting a patient encounter
   1. Use approved abbreviations
      1. Write “unit” and not U: can be mistaken for 0, 4, or cc
      2. Write “daily” or “every other day” and not Q.D. or Q.O.D.: mistaken for each other, periods can be mistaken for I
      3. No trailing zeroes (should be X mg, not X.0 mg) and have leading zeroes (0.X mg, and not .X mg)
   2. NO altered records: jeopardize malpractice defense, cancel coverage by liability insurer, criminal charges for fraud and perjury, medical license revocation (unprofessional conduct)
   3. Correct records properly
      1. Inaccurate errors: Single Strike-Thru (Initial, Date, Time, identified as “Error”)
   4. Add info properly
      1. Incomplete errors (adding info): Date, Time, Signature/Initials
3. Explain and identify components of a SOAP note
   1. S – Subjective – Info from patient or family
      1. Includes chief complaint, history of present illness through sexual/reproductive history and review of systems
   2. O – Objective – Info from your observations/examination
      1. Includes laboratory results and other diagnostic study results
   3. A – Analysis – Your impression or problem
      1. Includes differential diagnosis and reasoning behind medical impressions
   4. P – Plan – Your plan for treatment and follow-up
      1. May include meds and other diagnostic studies/therapies
4. Document a patient’s chief complaint (CC) and history of present illness (HPI)
   1. DO IT

**Taking a Sexual History – September 26, 2012**

***Objectives***

1. To describe importance of taking a comprehensive and compassionate sexual history for wellness, addressing chief complaint, identifying high-risk behaviors, and primary prevention
   1. Lifesaving – Pregnancy, AIDS, STDs
   2. Could be related to another disease or could be a side-effect (partner with infection, unprotected sex)
   3. Dysfunction as indicator of disease or medication side effect (CAD, antihypertensives)
      1. Men: erectile dysfunction, impotence
      2. Women: orgasm, desire, lubrication, pain
      3. Both: emotional/quality of life
   4. Risk management – STDs run rampant and need to be managed
      1. Include chlamydia, gonorrhea, syphilis, chancroid, herpes, trichomonas, HPV (50-60% of sexually active women), HIV, PID
   5. Primary prevention
   6. Sexual satisfaction
2. To examine one’s own attitudes toward sexuality and degree of comfort talking about sex with patients
   1. Don’t judge before treating the patient
   2. Use the proper terminology and don’t pull an Elliot Reed
   3. Remember that patients are scared to bring up this topic themselves and don’t want to get hurt so be respectful and know that you are doing it for them
3. To review general approach to taking sexual history through use of “*PLISSIT”* model
   1. P – Permission – allow the discussion to even take place
      1. Open-ended questions, give patient permission to talk, reassure that feelings are acceptable
   2. L – Limited Info – Dispel myths and provide facts during your visit
      1. Address what you can, educate, encourage follow-up visit
   3. SS – Specific Suggestions – Give suggestions directly related to the problem (small changes)
   4. IT – Intensive Treatment – Highly individualized therapy for complex situations (refer to the appropriate specialist)
4. To practice taking a sexual history with patient cases
   1. When to ask: during related symptoms (expand or clarify), Ob/Gyn history, health maintenance, social history, review of systems
   2. How to ask: use transition, establish confidentiality, be clear with medical terminology, be non-judgmental, don’t assume, acknowledge uncomfortable feelings, use eye contact and nodding

**Communicating with LEP Patients – September 26, 2012**

***Notes***

* **LEP:** limited-English proficient, individuals who don’t speak English as their primary language and who have a limited ability to read, write, speak, or understand English
* **LAS:** language access services, oral interpretation and written translation
* Barriers create decreased patient satisfaction, patient compliance, patient outcomes, increases diagnostic errors, return office visits and hospitalization rates
  + Increased medical costs, unnecessary testing
  + Legal issues: increased litigation from misdiagnosis

***Objectives***

1. Discuss the legal and policy requirements for providing language access services (LAS)
   1. Title VI of the Civil Rights Act of 1964
      1. Require recipients of federal financial assistance to take reasonable steps to provide meaningful access to LEP people, includes hospitals and physicians
      2. To avoid discrimination based on national origin
   2. National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards)
      1. 14 standards, 3 themes (culturally competent care, LAS mandates for all recipients of federal funds, organizational support for cultural competence)
         1. LAS must be offered at no cost to the patient
         2. Patient must be informed in their preferred language of their right to LAS
         3. Organizations must assure competence of LAS providers
         4. Availability of patient materials in languages of commonly encountered groups
   3. Accrediting Organizations – The Joint Commission
      1. Organization “respects the patient’s right to receive information in a manner he or she understands”
      2. Must be able to provide interpretation and translation services to be accredited (EP2)
   4. Hearing Impairments – Section 504 of the Rehab Act of 1973
      1. Protects from discrimination based on disability
      2. Recipients of federal funds must provide sign language interpreters for people with hearing impairments
2. Describe the dis/advantages of various strategies for providing interpretation services
   1. Bilingual Staff – Used when language is seen often, must be competent to deal directly with LEPs
   2. Staff Interpreters – Frequent need for interpreting services in 1 or more languages, can be expensive
   3. Contracted Professional Interpreters – Cost-effective when a language it not seen often
   4. Telephonic Interpreters Lines – Speedy and in many different languages but no visual component (can’t use nonverbal communication or nuances in language)
   5. Community Volunteers – Cost-effective supplemental LAS, but must assess competence
   6. Family Member/Friend – Patient may be more comfortable, can be used but LEP should know about professional services, brings up additional issues (omit or add info, bring emotions, conflicts of interest, confidentiality)
3. Recognize signs of professional and unprofessional interpretation
   1. Interpreter shouldn’t add options, add or omit info, give advice
   2. Physician shouldn’t look at interpreter (look at patient), don’t use 3rd person
4. Describe techniques to effectively guide an interpreter when conducting an interview with a limited-English proficient (LEP) patient
   1. Arrange seating with interpreter in background (not a triangle) and guide interpreter’s role
   2. Use first person and talk directly to the patient, eye contact
   3. Short sentences and 1 question at a time
   4. No slang or technical jargon
   5. Remind interpreter of role or correct them if needed
   6. Avoid side conversations with interpreter